

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0017319</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>ALDEN LAKELAND REHAB &amp; HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>820 W. LAWRENCE AVE.</u> <u>CHICAGO</u> <u>60640</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>COOK</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>STEVEN M. KROLL</u> (Title) <u>Chief Financial Officer</u>	
<b>Telephone Number:</b> <u>(773) 286-3883</u> <b>Fax #</b> <u>(773) 286-3743</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u>	
<b>IDPA ID Number:</b> <u>36-2687662</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>01/01/72</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>STEVEN M. KROLL</u> <b>Telephone Number:</b> <u>(773) 286-3883</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>300</u>	Skilled (SNF)		<u>109,500</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>300</u>	TOTALS		<u>109,500</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>32,269</u>	<u>2,422</u>	<u>5,197</u>	<u>39,888</u>	8
9	SNF/PED					9
10	ICF	<u>30,359</u>	<u>627</u>	<u>9</u>	<u>30,995</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>62,628</u>	<u>3,049</u>	<u>5,206</u>	<u>70,883</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 64.73%

D. How many bed-hold days during this year were paid by Public Aid?

none (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/72

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 120 and days of care provided 5,033Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number ALDEN LAKELAND REHAB &amp; HCC # 0017319 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	292,009	33,323	6,000	331,332	1,019	332,351		332,351			1
2	Food Purchase		476,083		476,083	(24,497)	451,586	11,589	463,175			2
3	Housekeeping	250,301	55,919		306,220	1,505	307,725		307,725			3
4	Laundry	76,120	20,960		97,080	326	97,406		97,406			4
5	Heat and Other Utilities			255,545	255,545		255,545	(5,194)	250,351			5
6	Maintenance	57,710	460	202,431	260,601	8,074	268,675	(32,414)	236,261			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	676,140	586,745	463,976	1,726,861	(13,573)	1,713,288	(26,019)	1,687,269			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			22,500	22,500		22,500		22,500			9
10	Nursing and Medical Records	2,135,536	370,919	18,813	2,525,268	5,812	2,531,080	(63,573)	2,467,507			10
10a	Therapy	100,556			100,556		100,556		100,556			10a
11	Activities	104,444	4,559	2,447	111,450	228	111,678		111,678			11
12	Social Services	47,588			47,588		47,588		47,588			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,388,124	375,478	43,760	2,807,362	6,040	2,813,402	(63,573)	2,749,829			16
	<b>C. General Administration</b>											
17	Administrative	258,332			258,332		258,332		258,332			17
18	Directors Fees											18
19	Professional Services			1,041,224	1,041,224	(30,142)	1,011,082	(957,190)	53,892			19
20	Dues, Fees, Subscriptions & Promotions			41,939	41,939	(10,635)	31,304	(17,665)	13,639			20
21	Clerical & General Office Expenses	616,255	21,140	95,368	732,763	10,840	743,603	89,611	833,214			21
22	Employee Benefits & Payroll Taxes			675,050	675,050	15,337	690,387	88,706	779,093			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,340	10,340	(5,670)	4,670	15,498	20,168			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			69,435	69,435		69,435	13,229	82,664			26
27	Other (specify):* <b>Bad Debt</b>			(14,510)	(14,510)		(14,510)	14,510				27
28	<b>TOTAL General Administration</b>	874,587	21,140	1,918,846	2,814,573	(20,270)	2,794,303	(753,301)	2,041,002			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,938,851	983,363	2,426,582	7,348,796	(27,803)	7,320,993	(842,894)	6,478,099			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC

#0017319

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation					126,859	126,859	477,499	604,358			30
31	Amortization of Pre-Op. & Org.							2,633	2,633			31
32	Interest			376,026	376,026		376,026	993,482	1,369,508			32
33	Real Estate Taxes			283,129	283,129	(252,987)	30,142	289,353	319,495			33
34	Rent-Facility & Grounds			1,157,794	1,157,794	283,129	1,440,923	(1,440,108)	815			34
35	Rent-Equipment & Vehicles			9,529	9,529	5,670	15,199	23,057	38,256			35
36	Other (specify):* <b>Mortg. Insurance</b>			134,868	134,868	(134,868)		92,434	92,434			36
37	<b>TOTAL Ownership</b>			1,961,346	1,961,346	27,803	1,989,149	438,350	2,427,499			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	1,213,356	585,801	1,130,094	2,929,251		2,929,251	(115,271)	2,813,980			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	1,213,356	585,801	1,294,344	3,093,501		3,093,501	(115,271)	2,978,230			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,152,207	1,569,164	5,682,272	12,403,643		12,403,643	(519,815)	11,883,828			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number ALDEN LAKELAND REHAB &amp; HCC

# 0017319

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	87,490	30		9
10	Interest and Other Investment Income	(367,168)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,795)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	192	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	14,510	27		24
25	Fund Raising, Advertising and Promotional	(17,193)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (285,964)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(178,954)		34
35	Other- Attach Schedule	(54,897)	pg 5a	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (233,851)		36
37	<b>(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (519,815)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ALDEN LAKELAND REHAB & HCC

ID# 0017319

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	PAC FEE-ILL HEALTH CARE	\$ (1,184)	20	1
2	BACK OUT NON-COST: GL 6966 LEGAL FEES COLI	(14,530)	21	2
3	Record addtl def. Maint. Exp to correct amount	4,480	6	3
4	Back out utility late fee	(9,632)	5	4
5	Real estate tax adj per pg 10 (see instructs pg 29)	17,115	33	5
6	back out marketing salaries gl 6701100009	(2,457)	21	6
7	offset r & m cost from insurance settlement	(48,688)	6	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(54,897)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number ALDEN LAKELAND REHAB &amp; HCC

# 0017319

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,795)	0	0	15,384	0	0	0	0	0	0	0	11,589	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(9,632)	0	4,438	0	0	0	0	0	0	0	0	(5,194)	5
6	Maintenance	(44,208)	0	11,823	0	0	0	(29)	0	0	0	0	(32,414)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(57,635)</b>	<b>0</b>	<b>16,261</b>	<b>15,384</b>	<b>0</b>	<b>0</b>	<b>(29)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(26,019)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(61,910)	(1,663)	0	0	0	0	0	0	(63,573)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(61,910)</b>	<b>(1,663)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(63,573)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,839	(964,029)	0	0	0	0	0	0	0	0	(957,190)	19
20	Fees, Subscriptions & Promotions	(18,185)	0	520	0	0	0	0	0	0	0	0	(17,665)	20
21	Clerical & General Office Expenses	(16,987)	0	32,329	67,226	7,043	0	0	0	0	0	0	89,611	21
22	Employee Benefits & Payroll Taxes	0	0	87,585	0	1,121	0	0	0	0	0	0	88,706	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	15,498	0	0	0	0	0	0	0	0	15,498	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	13,229	0	0	0	0	0	0	0	0	0	13,229	26
27	Other (specify):*	14,510	0	0	0	0	0	0	0	0	0	0	14,510	27
28	<b>TOTAL General Administration</b>	<b>(20,662)</b>	<b>20,068</b>	<b>(828,097)</b>	<b>67,226</b>	<b>8,164</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(753,301)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(78,298)</b>	<b>20,068</b>	<b>(811,836)</b>	<b>20,700</b>	<b>6,501</b>	<b>0</b>	<b>(29)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(842,894)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	87,490	375,957	12,564	0	1,488	0	0	0	0	0	0	477,499 30
31	Amortization of Pre-Op. & Org.	0	550	1,940	0	0	143	0	0	0	0	0	2,633 31
32	Interest	(367,168)	1,296,978	60,510	0	1,173	1,989	0	0	0	0	0	993,482 32
33	Real Estate Taxes	17,115	266,679	5,195	0	364	0	0	0	0	0	0	289,353 33
34	Rent-Facility & Grounds	0	(1,440,923)	815	0	0	0	0	0	0	0	0	(1,440,108) 34
35	Rent-Equipment & Vehicles	0	0	23,057	0	0	0	0	0	0	0	0	23,057 35
36	Other (specify):*	0	92,434	0	0	0	0	0	0	0	0	0	92,434 36
37	<b>TOTAL Ownership</b>	<b>(262,564)</b>	<b>591,675</b>	<b>104,081</b>	<b>0</b>	<b>3,025</b>	<b>2,132</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>438,350 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(20,667)	(45,455)	(49,149)	0	0	0	0	0	(115,271) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(20,667)</b>	<b>(45,455)</b>	<b>(49,149)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(115,271) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(340,861)</b>	<b>611,743</b>	<b>(707,755)</b>	<b>33</b>	<b>(35,929)</b>	<b>(47,017)</b>	<b>(29)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(519,815) 45</b>



Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See page 6k		See page 6k		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 1,440,923	Lawrence Avenue building Limited Partnership		\$	\$ (1,440,923)	1
2	V	32 Investment-RR	1,248	Lawrence Avenue building Limited Partnership			(1,248)	2
3	V	32 Investment-Misc	1	Lawrence Avenue building Limited Partnership			(1)	3
4	V	19 Accounting fees		Lawrence Avenue building Limited Partnership		3,700	3,700	4
5	V	19 Misc. Admin. Expenses		Lawrence Avenue building Limited Partnership		3,139	3,139	5
6	V	33 Real estate taxes		Lawrence Avenue building Limited Partnership		266,679	266,679	6
7	V	26 Property and liability Ins.		Lawrence Avenue building Limited Partnership		13,229	13,229	7
8	V	32 Interest on Mortgage Note		Lawrence Avenue building Limited Partnership		897,316	897,316	8
9	V	36 Mortgage insurance premium		Lawrence Avenue building Limited Partnership		92,434	92,434	9
10	V	32 Late charges on mortgage		Lawrence Avenue building Limited Partnership		53,732	53,732	10
11	V	32 Prepayment penalty on debt		Lawrence Avenue building Limited Partnership		347,179	347,179	11
12	V	30 Depreciation		Lawrence Avenue building Limited Partnership		375,957	375,957	12
13	V	31 Amortization		Lawrence Avenue building Limited Partnership		550	550	13
14	Total		\$ 1,442,172			\$ 2,053,915	\$ * 611,743	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 employee benefits	\$	Alden Management Services		\$ 87,585	\$ 87,585	15
16	V	19 profess. Fees	978,300	Alden Management Services		14,271	(964,029)	16
17	V	21 g & a		Alden Management Services		32,329	32,329	17
18	V	5 utilities		Alden Management Services		4,438	4,438	18
19	V	6 maintenance		Alden Management Services		11,823	11,823	19
20	V	24 auto/travel		Alden Management Services		15,498	15,498	20
21	V	20 subscriptions/etc		Alden Management Services		520	520	21
22	V	30 depreciation		Alden Management Services		12,564	12,564	22
23	V	31 amortization		Alden Management Services		1,940	1,940	23
24	V	33 real estate tax		Alden Management Services		5,195	5,195	24
25	V	34 rent		Alden Management Services		815	815	25
26	V	35 rent-equip/vehicles		Alden Management Services		23,057	23,057	26
27	V	32 interest		Alden Management Services		60,510	60,510	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 978,300			\$ 270,545	\$ * (707,755)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8
Schedule V	Line	Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)
15	V	2	\$ 150,910	Pyramid Health Care Services	100.00%	\$ 166,294	\$ 15,384
16	V	10	117,255	Pyramid Health Care Services		55,345	(61,910)
17	V	39	50,408	Pyramid Health Care Services		29,741	(20,667)
18	V	21		Pyramid Health Care Services		67,226	67,226
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 318,573			\$ 318,606	\$ * 33

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Drugs	\$ 104,576	Forum Extended Care II	100.00%	\$ 80,172	\$ (24,404)	15
16	V	10 House stock	7,128	Forum Extended Care II		5,465	(1,663)	16
17	V	39 IV	90,204	Forum Extended Care II		69,153	(21,051)	17
18	V	22 Employee benefits		Forum Extended Care II		1,121	1,121	18
19	V	21 G & A		Forum Extended Care II		7,043	7,043	19
20	V	32 Interest		Forum Extended Care II		1,173	1,173	20
21	V	33 Real estate taxes		Forum Extended Care II		364	364	21
22	V	30 Depreciation		Forum Extended Care II		1,488	1,488	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 201,908			\$ 165,979	\$ * (35,929)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Therapy	\$ 1,116,387	Community Physical Therapy	100.00%	\$ 1,067,238	\$ (49,149)	15
16	V	32 Interest		Community Physical Therapy		1,989	1,989	16
17	V	31 Amortization		Community Physical Therapy		143	143	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,116,387			\$ 1,069,370	\$ * (47,017)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC# 0017319Report Period Beginning: 01/01/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	6 maintenance expense	\$ 9,849	Alden Bennett Construction	100.00%	\$ 9,820	\$ (29)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 9,849			\$ 9,820	\$ * (29)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

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Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	President	President	Chief Executive	100.00	338,401	2.74	6.83	SALARY	\$ 24,812	17-1	1
2	Nurse coordinator	Nurse coordinator	nursing admin.	0.00	85,447	2.74	6.83	SALARY	6,265	17-1	2
3	Maint. Supervisor	Maint. Supervisor	construct/mainten	0.00	80,054	2.74	6.83	SALARY	5,862	17-1	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	\$ 36,939		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDEN LAKELAND REHAB & HCC # 0017319 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.  
 Street Address 4200 W. Peterson Ave.  
 City / State / Zip Code Chicago, IL 60646  
 Phone Number ( 773 ) 286-3883  
 Fax Number ( 773 ) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	see page 8A (also on page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25



**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related Long-Term														
1	Prudential		x	mortgage	varies	3/94	\$			paid off		\$	648,280	1	
2	Cambridge		x	mortgage	\$67,071.69	8/27/02		11,977,000	11,959,542		6.1400		249,036	2	
3														3	
4	other		x											4	
5	Prepayment fee on lt debt		x	payoff of old loan									400,911	5	
	Working Capital														
6	Related Party - AMS	X		Working Capital									68,119	6	
7	Related party - FECH	X		Working Capital									1,173	7	
8	Related party - CPT	X		Working Capital									1,989	8	
9	TOTAL Facility Related				\$67,071.69		\$	11,977,000	\$	11,959,542			\$	1,369,508	9
	B. Non-Facility Related*														
10														10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$				\$		14
15	TOTALS (line 9+line14)						\$	11,977,000	\$	11,959,542			\$	1,369,508	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 92,434 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **ALDEN LAKELAND REHAB & HCC**# **0017319** Report Period Beginning: **01/01/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2001 report.			\$	<b>346,000</b> 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>346,350</b> 2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>350</b> 3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>356,700</b> 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>30,142</b> 5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ 90,371 For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>(73,257)</b> 6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>313,935</b> 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	<b>368,272</b>	8	
	1998	<b>354,967</b>	9	
	1999	<b>372,295</b>	10	
	2000	<b>337,570</b>	11	
	2001	<b>346,350</b>	12	
<b>accrual based on 3% increase over prior yr bill.</b>				
				<b>FOR OHF USE ONLY</b>
13 FROM R. E. TAX STATEMENT FOR 2001 \$				13
14 PLUS APPEAL COST FROM LINE 5 \$				14
15 LESS REFUND FROM LINE 6 \$				15
16 AMOUNT TO USE FOR RATE CALCULATION \$				16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME ALDEN LAKELAND REHAB & HCC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0017319

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-08-419-040-0000</u>	<u>Nursing Home Facility</u>	\$ <u>346,349.53</u>	\$ <u>346,349.53</u>
2. _____	<u>Related Party - Alden Management</u>	\$ <u>76,052.00</u>	\$ <u>5,195.00</u>
3. _____	<u>Related Party - Forum</u>	\$ <u>8,608.00</u>	\$ <u>364.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>431,009.53</u></u>	\$ <u><u>351,908.53</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

C. Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	300 bed facility		1995	\$ 1,040,001	1
2					2
3	TOTALS			\$ 1,040,001	3

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	related party-forum			1978	\$ 18,359	\$	22	\$		\$ 18,359	4
5	300			1978	8,882,363	221,780	40	222,059	279	1,893,757	5
6			1995		577		40	14	14	106	6
7			1995		245		40	6	6	45	7
8				1996	13,250	331	40	331	(0)	2,291	8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.
 See Page 12A, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	GENERAL REMODELING	1994	\$ 1,640,753	\$ 42,645		\$ 109,384	\$ 66,739	\$ 879,629		37
38	NEW AIR CONDITIONER	1994	185,718	4,827		12,381	7,554	93,521		38
39	OXYGEN AND SUCTION SYSTEM	1994	89,080	2,315		5,939	3,624	47,175		39
40	3RD FLOOR NURSES STATION	1994	14,234	370		949	579	7,262		40
41	REBUILD SHOWERS AND STALL	1994	47,131	1,225		3,142	1,917	24,486		41
42	PATIENT ROOM LIGHTING	1994	34,763	903		2,318	1,415	17,736		42
43	CARPETING	1994	20,688	537		1,379	842	14,548		43
44	NEW DOOR LOCK AND HARDWARE	1994	25,312	658		1,687	1,029	18,008		44
45	VARIOUS OTHER ITEMS	1994	85,896	2,234		5,726	3,492	43,813		45
46	DECORATING	1986	5,000		3			5,000		46
47	DOCORATING,PUMPS, ROOF REPAIR, COMPRESSOR REPAIR	1987	15,543		3-5			15,543		47
48	ELECTRICAL REPAIRS, CARPENTRY,PUMP REPAIR	1988	15,804		5			15,804		48
49	PUMP REPAIR	1989	2,510		5			2,510		49
50	REPAIR: PUMPS AND COMPRESSOR	1990	32,782		5-10			32,782		50
51	REPAIR: PUMPS, FANS, HEATER,ROOF	1991	16,753		5			16,753		51
52	REPAIR: BOILER,FANS, THERMOSTAT	1992	32,033	233	5-20	233		31,482		52
53	COLOR RENDERING,REPAIR: COOLING TOWER, ELECT TIMER	1993	8,916	490	5-15	490		6,255		53
54	DRAPERIES AND CUBICLES; COMPRESSOR REPAIR	1994	45,438	1,541	5-20	1,541		39,203		54
55	REPAIR: ELEVATOR, LAUNDRY ROOM, PUMPS,A.C, INSULLATIO	1995	415,705	22,315	5-20	22,315		194,712		55
56	NEW ELECTRIC GENERATOR, NEW COOLING TOWER	1996	191,725	9,510	5-20	9,510		66,507		56
57	INSTALL NEW CIRCUITS	1997	2,176	36	5	36		2,176		57
58	CLEAN FAN COILS	1997	4,622	385	5	385		4,622		58
59	REPAIR LIGHTING CIRCUIT & BALLAST	1997	2,327	155	5	155		2,327		59
60	REBUILD COMPRESSOR	1997	4,268	427	5	427		4,268		60
61	REPAIR CALL LIGHTS	1997	2,350	313	5	313		2,350		61
62	ISTALL NEW SMOKE DETECTOR	1997	2,661	355	5	355		2,661		62
63	SPRAYED FIREPROOFING	1997	3,965	595	5	595		3,965		63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 11,862,947	\$ 314,180		\$ 401,670	\$ 87,490	\$ 3,509,657		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,862,947	\$ 314,180		\$ 401,670	\$ 87,490	\$ 3,509,657	1
2	Climate Service, Inc (replace fans)	1998	4,725	945	5	945		4,725	2
3	**Wigdahl(replaced outlets)	1998	2,300	230	10	230		1,131	3
4	Wigdahl(replaced outlets)	1998	334	33	10	33		164	4
5	Long Elevator(modify restrictors)	1998	2,200	110	20	110		532	5
6	Incorporation(kickplates & correr guards)	1998	2,309	462	5	462		2,232	6
7	Incorporation(kickplates & larone)	1998	4,547	909	5	909		4,320	7
8	Shine Rite Maintenance (strip and refinish 30 rooms)	1998	6,480	1,296	5	1,296		6,156	8
9	Star Contractors (install locks)	1998	5,581	558	10	558		2,698	9
10	Supreme Sheet Metal (Fire dampers)	1998	10,000	667	15	667		3,000	10
11	CSI (replace fan coil units)	1998	6,340	423	15	423		1,832	11
12	Atash Fire & Safety (install annunciator panel)	1998	5,890	393	15	393		1,800	12
13	CSI (rebuild compressor)	1998	7,056	470	15	470		2,038	13
14	Supreme Sheet Metal (install fire dampers)	1998	11,680	1,168	10	1,168		4,964	14
15	Alden Bennett Construction (plan of correction)	1998	2,222	222	10	222		926	15
16	Supreme Sheet Metal (install fire dampers)	1998	7,750	775	10	775		3,165	16
17	Supreme Sheet Metal (install fire dampers)	1999	9,475	948	10	948		3,790	17
18	Patton (repair generator)	1999	1,702	114	15	114		454	18
19	Alden Bennett Construction(general)	1999	11,471	1,147	10	1,147		3,919	19
20	Welding Supply(oxygen piping installed)	1999	13,176	659	20	659		2,141	20
21	ISS/Chicago Sound & Comm.(call system)	1999	28,500	1,900	15	1,900		6,017	21
22	Alden Bennett Construction(general)	1999	23,289	1,571	15	1,571		4,843	22
23	Alden Bennet Construction- oxygen tank	1999	9,475	474	20	474		1,421	23
24	Alden Bennett Construction(oxyg tank)	1999	35,016	1,751	20	1,751		5,398	24
25	Supreme sheet metal-install fire dampers-delete duplicate	2000	(9,475)	(948)	10	(948)		(2,843)	25
26	Climate Service, Inc (repair boiler)	2000	4,892	245	20	245		693	26
27	A&B custom cable-install cable tv	2000	13,824	1,382	10	1,382		3,802	27
28	Fox Valley-install new fire safety pump	2000	4,423	221	20	221		608	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,088,129	\$ 332,304		\$ 419,794	\$ 87,490	\$ 3,579,582	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,221,241	\$ 347,870		\$ 435,360	\$ 87,490	\$ 3,620,530	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	19,335		20			19,334	4
5	Leasehold Improvement-Remodeling	1980	1,208		10			1,208	5
6	Leasehold Improvement-Remodeling	1986	645		5			645	6
7	Leasehold Improvement-Remodeling	1990	404		5			404	7
8	Leasehold Improvement-Remodeling	1991	94		5			94	8
9	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		8,304	9
10	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469		6,504	10
11	Leasehold Improvement-sign	1994	261	22	12	22		174	11
12	Leasehold Improvement-dryvit	1995	443	44	10	44		310	12
13	Leasehold Improvement-new ac	1999	723	48	15	48		145	13
14	Leasehold Improvement-roof	1985	972	52	19	52		922	14
15	Leasehold Improvement-roof	1994	863	58	15	58		518	15
16	Leasehold Improvement-roof	1997	819	55	15	55		328	16
17	Leasehold Improvement-roof	1998	1,390	93	15	93		464	17
18	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		33	18
19	Leasehold Improvement-hallway lighting	2001	155	16	10	16		32	19
20	Leasehold Improvement-DAI	2001	195	19	10	19		38	20
21	Leasehold Improvement-bathrooms	2002	687	69	10	69		69	21
22	Leasehold Improvement-Remodeling	2002	98	20	5	20		20	22
23	Related Party-AMS:								23
24	Leasehold Improvement-Remodeling	1993	4,266		7			4,266	24
25	Leasehold Improvement-Remodeling	1994	2,112		7			2,112	25
26	Leasehold Improvement-Remodeling	2002	5,221		7				26
27									27
28									28
29									29
30									30
31									31
32	Related Party-Forum Ext. Care	1999	1,764	268	40	268		451	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,277,815	\$ 349,944		\$ 437,434	\$ 87,490	\$ 3,666,905	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,094,504	\$ 160,555	\$ 160,555	\$	varies	\$ 283,944	71
72	Current Year Purchases	21,956	1,892	1,892		varies	1,892	72
73	Fully Depreciated Assets	222,012	688	688		varies	222,013	73
74								74
75	TOTALS	\$ 2,338,472	\$ 163,135	\$ 163,135	\$		\$ 507,849	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine, bus,van	dodge	'98-'02	\$ 12,336	\$ 3,788	\$ 3,788	\$	3	\$ 9,992	76
77										77
78										78
79										79
80	TOTALS			\$ 12,336	\$ 3,788	\$ 3,788	\$		\$ 9,992	80

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 15,668,624	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 516,868	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 604,358	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 87,490	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,184,746	85

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$ n/a	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party, cost is backed out.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>related party, cost is eliminated</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 9,529

Description: copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>transport-non-patients</u>		\$ <u>472.50</u>	\$ <u>5,670</u>	17
18					18
19	<u>related party - AMS</u>		<u>1,921.42</u>	<u>23,057</u>	19
20					20
21	TOTAL		\$ <u>2,393.92</u>	\$ <u>28,727</u>	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2003 \$                     

13.                      /2004 \$                     

14.                      /2005 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>Skilled nurses on site</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 163,143	\$		\$ 163,143	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			81,701			81,701	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			172,263			172,263	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See page 16a	# of prescrpts				64,393		64,393	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1, 39-3		1,213,356			455,925		1,669,281	12
13	Other (specify):	See page 16a					663,199		663,199	13
14	TOTAL			\$ 1,213,356		\$ 417,107	\$ 1,183,518		\$ 2,813,980	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	42,239	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 155,943 )	1,936,197	1,936,197	3
4	Supply Inventory (priced at )	264	264	4
5	Short-Term Investments		258,854	5
6	Prepaid Insurance	6,075	65,141	6
7	Other Prepaid Expenses	3,357	3,357	7
8	Accounts Receivable (owners or related parties)		939,697	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,945,892	\$ 3,245,748	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		65,980	12
13	Land			13
14	Buildings, at Historical Cost	90,365	13,794,607	14
15	Leasehold Improvements, at Historical Cost	1,345,434	1,345,434	15
16	Equipment, at Historical Cost	834,698	834,698	16
17	Accumulated Depreciation (book methods)	(1,266,563)	(4,431,534)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Due from affiliates		211,504	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,003,935	\$ 11,820,690	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,949,827	\$ 15,066,438	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 684,954	\$ 684,954	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,373	44,373	28
29	Short-Term Notes Payable	64,070	136,634	29
30	Accrued Salaries Payable	393,391	393,391	30
31	Accrued Taxes Payable (excluding real estate taxes)	68,749	68,749	31
32	Accrued Real Estate Taxes(Sch.IX-B)		356,700	32
33	Accrued Interest Payable		61,193	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Due to BCBS, IDPA & other accr exp	330,028	345,389	36
37	Due to affiliates	9,777,289	9,777,289	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 11,362,855	\$ 11,868,673	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	167,951	12,054,929	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 167,951	\$ 12,054,929	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 11,530,806	\$ 23,923,602	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (8,580,979)	\$ (8,857,164)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,949,827	\$ 15,066,438	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (7,691,385)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>external audit adjustments made after 2001 cost report was</b>		<b>3</b>
<b>4</b>	<b>submitted. These have no effect on prior years report:</b>	<b>8,877</b>	<b>4</b>
<b>5</b>	<b>Bad debt, Medicare revenues (non-allowables)</b>		<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (7,682,508)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(898,471)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (898,471)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (8,580,979)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,195,131	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,195,131	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients	599,276	5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 599,276	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	117	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 117	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	write off of old a/p's and other misc. income	17,102	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 17,102	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,811,625	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,726,861	31
32	Health Care	2,807,362	32
33	General Administration	2,814,573	33
<b>B. Capital Expense</b>			
34	Ownership	1,961,346	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,929,251	35
36	Provider Participation Fee	164,250	36
<b>D. Other Expenses (specify):</b>			
37	Related party salaries allocations	(693,547)	37
38	not included on this page, but included		38
39	on page 3&4.		39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,710,096	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(898,471)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (898,471)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



## STATE OF ILLINOIS

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Facility Name & ID Number ALDEN LAKE LAND REHAB & HCC# 0017319Report Period Beginning: 01/01/2002Ending: 12/31/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,762	1,868	\$ 47,781	\$ 25.58	1
2	Assistant Director of Nursing	775	959	19,849	20.70	2
3	Registered Nurses	53,259	57,794	1,696,346	29.35	3
4	Licensed Practical Nurses	20,190	21,563	475,811	22.07	4
5	Nurse Aides & Orderlies	95,658	100,810	992,717	9.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,567	2,791	27,879	9.99	8
9	Activity Director	1,912	2,053	34,734	16.92	9
10	Activity Assistants	6,763	7,491	69,711	9.31	10
11	Social Service Workers	2,524	2,672	46,010	17.22	11
12	Dietician					12
13	Food Service Supervisor	1,951	2,127	32,292	15.18	13
14	Head Cook	5,746	6,308	56,956	9.03	14
15	Cook Helpers/Assistants	25,778	27,178	202,761	7.46	15
16	Dishwashers					16
17	Maintenance Workers	1,930	2,010	34,296	17.06	17
18	Housekeepers	27,386	29,500	250,301	8.48	18
19	Laundry	6,888	7,536	75,860	10.07	19
20	Administrator	72	80		0.00	20
21	Assistant Administrator	624	640	12,801	20.00	21
22	Other Administrative	5,425	5,964	108,330	18.16	22
23	Office Manager					23
24	Clerical	4,379	4,607	56,052	12.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,799	3,247	92,736	28.56	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,605	1,850	23,910	12.92	31
32	Other Health C: Clinical SS	2,337	2,425	74,256	30.62	32
33	Other(specify) <u>Security</u>	2,056	2,122	30,293	14.28	33
34	TOTAL (lines 1 - 33)	274,386	293,595	\$ 4,461,682 *	\$ 15.20	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,000	1-3	35
36	Medical Director	Monthly	22,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	19,200	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,944	11-3	44
45	Social Service Consultant	9	504	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	45	\$ 50,148		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **ALDEN LAKELAND REHAB & HCC**# **0017319**Report Period Beginning: **01/01/2002**Ending: **12/31/2002****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount		
Argamso, M	administrator	0	\$ 97,260	Workers' Compensation Insurance	\$ 87,851	IDPH License Fee	\$		
				Unemployment Compensation Insurance	48,665	Advertising: Employee Recruitment			
				FICA Taxes	340,721	Health Care Worker Background Check			
				Employee Health Insurance	51,473	(Indicate # of checks performed _____)			
Tannen, M	assist. Admin.	0	57,152	Employee Meals	24,497				
				Illinois Municipal Retirement Fund (IMRF)*		Surety Bond Fees, Dues & Subscriptions	1,415		
various executives / assit admin.	executive admin	0	103,920	Related party - FECH	1,121	II. Health Care Assoc.	11,704		
TOTAL (agree to Schedule V, line 17, col. 1)				Union Health & Welfare	81,919				
(List each licensed administrator separately.)			\$ 258,332	Dental, Life & Pension Costs	23,998				
B. Administrative - Other				Relations, Misc., Background Cks. & Tuition	24,351	Related Party - AMS	520		
Description			Amount	Drug Tests, 401k Match, Vaccinations	6,912	Less: Public Relations Expense	( )		
			\$			Non-allowable advertising	( )		
				Related Party - AMS	87,585	Yellow page advertising	( )		
				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	\$ 779,093		\$ 13,639			
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount		
AMS	Management Fees	\$ 978,300				Out-of-State Travel	\$		
BDO Seidman	Accounting Fees	11,535							
Ken Fisch / Greenberg	Legal Fees	15,265				In-State Travel			
Comprehensive Therapeutics	Consulting Services	648				Misc. Gas & Repairs	2,388		
Janet L. Hermann	Legal Services	1,907							
Medi.Com	Billing Consultants	502				Related Party - AMS	15,498		
U S Gas & Energy Corp	Utilities	2,925				Seminar Expense			
Schmidt	Legal Services - Tax Refund	30,142				Comprehensive Therapeutics	500		
						O.C.C. / Life Serv Network	560		
						Health Info. Network & Other	1,222		
						Entertainment Expense	( )		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		(agree to Sch. V, line 24, col. 8)			
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 1,041,224	\$		\$ 20,168			

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	hvac/pipes/pumps/repairs	1/88	\$ 3,500	5	\$	\$	\$	\$	\$	\$	\$	\$	\$
2	hvac/pipes/pumps/repairs	2/88	2,444	5									
3	hvac/pipes/pumps/repairs	3/88	2,385	5									
4	hvac/pipes/pumps/repairs	7/88	1,766	5									
5	hvac/pipes/pumps/repairs	10/88	3,200	5									
6	hvac/pipes/pumps/repairs	12/88	2,510	5									
7	boiler/hvac repair	6/89	5,114	5									
8	fan/pump/boiler repairs	10/90	4,240	5									
9	fan/pump/boiler repairs	11/90	3,482	5									
10	fan/pump/boiler repairs	12/90	2,233	5									
11	see page 22a	1991-1995	220,093	5-20	32,213	2,100	1,540	1,540	1,540	1,540	1,540	1,540	1,540
12	see page 22b	1996	41,372	3-20	5,956	2,976	1,566	696	696	696	696	555	505
13	see page 22c	1997	16,366	3	5,455	2,471	0						
14	see page 22c	1998	103,843	3	34,614	34,614	9,693	0					
15	see page 22d	1999	18,157	3	3,032	6,052	6,052	3,021	0				
16	painting>\$1,500 ytd 1999	7/99	12,619	3	2,103	4,206	4,206	2,103	0				
17	see page 22d	2000	15,388	3		2,166	4,997	5,129	2,964	133	0		
18													
19													
20	TOTALS		\$ 458,712		\$ 83,373	\$ 54,585	\$ 28,054	\$ 12,489	\$ 5,200	\$ 2,369	\$ 2,236	\$ 2,095	\$ 2,045

[illegible]

Facility Name & ID Number ALDEN NURSING CENTER - LAKELAND 0017319 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month/Yr Improvement	Total Cost	Useful Life	Amount of Expense Amortized Per Year							FY2006.	FY2007
				FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005		
Painting	1/96	1,430	3	0								
Painting	2/96	1,430	3	119	0							
Painting	3/96	2,585	3	143	0							
Coils	3/96	2,200	5	440	440	73						
Pipes	3/96	4,900	15	327	327	327	327	327	327	327	327	327
Painting	4/96	1,886	3	156	0							
Refrigerant	4/96	1,912	10	191	191	191	191	191	191	191	50	
Condenser cleaning	4/96	1,941	5	388	388	98	0					
Painting	5/96	1,610	3	178	0							
Condenser leak	5/96	1,824	5	365	365	121	0					
Bearings	5/96	3,284	5	657	657	218						
Feeder pump and motor	6/96	1,636	15	109	109	109	109	109	109	109	109	109
Boiler	6/96	1,389	20	69	69	69	69	69	69	69	69	69
RemoverRTV and clean	6/96	291	3	40	0							
Painting	6/96	2,254	3	314	0							
Painting	7/96	1,610	3	268	0							
Painting	8/96	1,610	3	312	0							
Painting	10/96	3,220	3	806	0							
Painting	11/96	1,104	3	307	0							
New water coil	11/96	2,152	5	430	430	360	0					
Painting	12/96	1,104	3	337	0							
Total to page 22, line 12		41,372		5,956	2,976	1,566	696	696	696	696	555	505

Facility Name & ID Number ALDEN NURSING CENTER - LAKELAND 0017319 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month/Yr Improvement	Total Cost	Useful Life	Amount of Expense Amortized Per Year								FY2007
				FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	
replace pump & motor	4/97	2,205	3	735	184	0	0	0	0	0	0	0
replacing mixing valves&pump	4/97	1,053	3	351	88	0						
replace belts& motor pulley	7/97	1,800	3	600	300	0						
replace valve & drier	7/97	2,686	3	895	448	0						
replace butterfly valve	11/97	2,883	3	961	801	0						
replaced valves	4/97	2,631	3	877	219	0						
replace butterfly valve	6/97	1,539	3	513	214	0						
replaced fuses, motor&starter	6/97	1,570	3	523	218	0						
Total to page 22, line 13		16,366		5,455	2,471	0	0	0	0	0	0	0
Boiler	3/98	2,378	3	793	793	133	0					
Drawings	3/98	2,000	3	667	667	111	0					
Painting	3/98	36,726	3	12,242	12,242	2,040	0					
Painting	4/98	6,080	3	2,027	2,027	507	0					
Painting	4/98	41,270	3	13,757	13,757	3,440	0					
Painting	7/98	3,574	3	1,191	1,191	595	0					
Chiller	7/98	3,026	3	1,009	1,009	505	0					
Fan coil units	9/98	1,671	3	557	557	371	0					
Painting	10/98	3,276	3	1,092	1,092	819	0					
Painting	12/98	3,843	3	1,281	1,281	1,174	0					
Total to page 22, line 14		103,843		34,614	34,614	9,693	0	0	0	0	0	0

Facility Name & ID Number ALDEN NURSING CENTER - LAKELAND 0017319 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month/Yr Improvement	Total Cost	Useful Life	Amount of Expense Amortized Per Year							FY2006	FY2007
				FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005		
Chicago Cooling(start/check a/c)	6/99	4,988	3	970	1,663	1,663	693	0				
Chicago Cooling(charge of a/c)	6/99	2,892	3	562	964	964	402	0				
CSI(cleaned and repair a/c unit)	7/99	2,359	3	393	786	786	393	0				
CSI(cut up dumpsters)	7/99	3,275	3	546	1,092	1,092	546	0				
CSI	8/99	3,122	3	434	1,041	1,041	607	0				
Village Plumbing	10/99	1,523	3	127	508	508	381	0				
<b>Total to page 22, line 15</b>		<b>18,157</b>		<b>3,032</b>	<b>6,052</b>	<b>6,052</b>	<b>3,021</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
painting>\$1,500 ytd 2000	7/00	7,132	3	0	1,189	2,377	2,377	1,189	0			
capps plumbing/sewer-repair plumb	7/00	1,824	3	0	304	608	608	304	0			
gt mechanical-replace hvac pump motor	8/00	2,534	3	0	351	845	845	493	0			
gt mechanical-repair hvac condens/pump	8/00	2,314	3	0	322	771	771	450	0			
capps plumbing/rodding/testing)	4/01	1,585	3			396	528	528	133	0		
<b>Total to page 22, line 17</b>		<b>15,388</b>		<b>0</b>	<b>2,166</b>	<b>4,997</b>	<b>5,129</b>	<b>2,964</b>	<b>133</b>	<b>0</b>	<b>0</b>	<b>0</b>

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. IL Healthcare Assoc. \$11,704
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,369 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ \_\_\_\_\_  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? n/a For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 24,497 Has any meal income been offset against related costs? n/a Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a  
c. What percent of all travel expense relates to transportation of nurses and patients? n/a  
d. Have vehicle usage logs been maintained? n/a  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
g. Does the facility transport residents to and from day training? no  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: BDO Seidman The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.